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Keywords

mental illness, identity, normalcy, marginalization, North America

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'Passing for Normal', 'More Than Passing Strange' and Other Strategies: Identity Deconstruction and Reconstruction among the "Mentally Ill"

Nadine Quehl

People who belong to marginalized groups sometimes utilize normalizing statements in order to contest their marginalization; others who are "on the edge," contest such normalization, instead emphasizing their differences. In terms of individuals with mental illnesses, some researchers have argued that normalizing contributes to the creation of a more positive, personal identity, and can even help change the boundaries and meanings of illnesses. Others insist that normalization encourages an eradication of difference and marginality, leading to homogeneity. By transforming the meaning of life at the margins, this contested site is divested of elements of defiance. Drawing from the work of medical anthropologists who have studied individuals with mental illness, this paper examines how, in a North American context, individuals with mental illnesses negotiate among these various strategies.

On the "Normal" and the "Healthy"

To begin such an exploration, it is first necessary to return to conceptualizations of "normal" and "normalization," which are both complex and ambiguous. Etymologically, "norma" means a T-square, and normal is that which neither bends to the right nor the left, and it is from this that the two meanings of normal originate: normal is that which is as it should be, and normal is that which represents the majority of cases of a certain kind, or the average. The obvious ambiguity in the term is that "normal" refers to a fact *and* a value attributed to the fact by virtue of the speaker's evaluative judgment (Canguilhem 1978:69). Philosopher of science and historian of medicine, Georges Canguilhem (1978:23) has pointed out that to define the abnormal as excess or deficiency is to recognize the normative character of the "normal." The normal state is a manifestation of an attachment to some value:

strictly speaking a norm does not exist, it plays its role which is to devalue existence by allowing its correction. To say that perfect health does not exist is simply saying that the concept of health is not one of an existence, but of a norm whose function and value is to be brought into contact with existence in order to stimulate modification (Canguilhem 1978:37).

Interestingly, the idea of the normal depends on the possibility of violating the norm, and the consequent need to "stimulate modification" is one of the meanings of "normalization" to which we will return. While it goes unquestioned by many that what constitutes "normal" is what constitutes "health," Canguilhem (1978:68) describes the historical development of this idea. Physicians relied primarily on physiology – "the science of the normal man" – to identify norms, and restore functions that deviate from these standards. Physiological constants are "normal" since they refer to average characteristics, which are most frequently observable; however, they are also "normal" because they are involved in the normative activity of "therapeutics."

Because "health" is both a descriptive and a normative concept, Canguilhem (1978:77) is able to state that perfect health on a continual basis is abnormal since the experience of living includes disease. Moreover, he deconstructs the healthy-normalcy equation by explaining that, "what characterizes health is the possibility of transcending the norm, which defines the

momentary normal, the possibility of tolerating infractions of the habitual norm and instituting new norms in new situations" (Canguilhem 1978:115). "Healthy," then, is a state in which one feels "more than normal." Still, as Rose (1994:67-8, cited in Lupton 1997:100) points out, the linkage between health and the idea of the "normal" person persists, since medicine, "has come to link the ethical question of how we should behave to the scientific question of who we truly are and what our nature is as human beings ... as simultaneously unique individuals and constituents of a population."

While the idea of variation as pathology has been dominant for several decades (Davis and Bradley 2000:9), re-examining the concepts, "norma," "nomos," "anomaly" and "abnormal," leads Canguilhem (1978:82) to state not only that diversity is not disease, but that the pathological does not signify the absence of a biological norm; in fact, it is another norm that is marginalized by life. Indeed, if pathological phenomena are the modifications of normal phenomena, the pathological must be comprehended as one type of normal:

without being absurd, the pathological state can be called normal to the extent that it expresses a relationship to life's normativity. ... this normal could not be termed identical to the normal physiological state because we are dealing with other norms. The abnormal is not such because of the absence of normality. There is no life whatsoever without norms of life, and the morbid state is always a certain mode of living (Canguilhem 1978:137).

The nature of disease, for she who is sick, is really another way of life: "the pathological state is not a simple, quantitatively varied extension of the physiological state, but something else entirely" (Canguilhem 1978:45). This contrasts with the dominant theory of the eighteenth century concerning the relations between the normal and the pathological, which held that pathological phenomena were merely quantitative variations, based on physiological phenomena. Canguilhem (1978:13) seems to be arguing for a return to earlier theories of qualitative conceptualization where the pathological differed from the normal, as one quality differs from another (Canguilhem 1978:13).

Those who are diagnosed with "mental illnesses," then, can be said to be living another

life: "the madman is 'out of his mind' not so much in relation to other men as to life: he is not so much deviant as different" (Canguilhem 1978:64). During his discussion of "insanity," Canguilhem (1978:66) makes the following statement that will be variously accepted and challenged in the discourses of normalization to which we will turn in the second part of this paper:

it is the patients who most often decide – and from very different points of view – whether they are no longer normal or whether they have returned to normality. ... future is almost always imagined starting from past experience, becoming normal again means taking up an interrupted activity or at least an activity deemed equivalent by individual tastes or the social values of the milieu.

"Normalization"

Canguilhem (1987:146) explains normalizing as, "imposing a requirement on an existence, a given whose variety, disparity, with regard to the requirement, present themselves as a hostile, even more than an unknown, indeterminant." Between 1759 and 1834, the years that the words "normal" and "normalized" appeared, respectively, a normative class gained the ability to identify the function of social norms, as well as to determine the content (Canguilhem 1978:151). Canguilhem (1978:69) asks whether it is because therapeutics aims at this state as a positive goal to obtain that it is called "normal," or whether it is because the sick person considers it "normal" that therapeutics aim at it.

While he agrees with the latter, a Foucauldian approach would agree with the former and problematize the latter. "Philosopher-historian," Michel Foucault, (1978:41) focuses on how therapeutics put into effect mechanisms of control and surveillance, and explains how the "norm" assumed greater importance than the legal system: "... a power whose task is to take charge of life needs continuous regulatory and corrective mechanisms. ... it effects distributions around the norm" (Foucault 1978:144). Foucault (1977:184) also explains how normalization leads to homogeneity, but it also individualizes by making it possible to determine levels, and then make the differences useful by fitting them together. We are "individualized" so that we can be better "managed."

By "normalization," Foucault means a system of measurable intervals in which people can be distributed around a norm that both organizes and is the result of this distribution. Technologies of normalization first isolate anomalies, and then normalize them by corrective or therapeutic procedures, all of which are purportedly to deal with dangerous deviants; however, as Foucault shows, the rise of bio-power occurs at the same time as the appearance of modern "anomalies," so that "perversions" seem to be invented in order to be normalized (Rabinow 1984:21). For example, in *Madness and Civilization* (1965), Foucault showed how conceptions of "sanity" and "insanity" arose in the eighteenth century as a result of the attempts of the asylum keepers to manage nonconformist behavior.

Foucault's early work emphasized external technologies of domination: "I...tried to show how we have indirectly constituted ourselves through the exclusion of some others: criminals, mad people ..." (Foucault 1988:146). His later work on technologies of the self aligns him, in a certain sense, closer to Canguilhem's approach to therapeutics and "the normal," evident in the question he explores: "How did we directly constitute our identity through some ethical techniques of the self which developed through antiquity down to now?" (Foucault 1988:146). This statement connotes a sense of individual agency, where, like Canguilhem, Foucault seems to suggest that because the sick person considers it "normal," she tries to shape herself according to this "norm." On the other hand, it can also refer to Foucault's notion of self-surveillance that emerges as a practice of control.

The concept of "normalization" arose in Denmark where it referred to the creation of living conditions for the "mentally retarded" that are as close to normal as possible, a goal that was set out in the 1959 Mental Retardation Act (Bank-Mikkelsen 1980:56, cited in Emerson 1992:2). The definition was expanded and redefined, but continued to emphasize freedom of choice and right to self-determination; since equality was defined in terms of having rights to the same quality of life as non-disabled people, integration was not necessarily a prerequisite of equality (Emerson 1992:3). The North American version of "normalization" was developed by Wolfensberger (1972:28, cited in Emerson 1992:4) to refer to, "utilization of means which are as culturally normative as possible, in order

to establish and/or maintain personal behaviors and characteristics which are as culturally normative as possible." While the Scandinavian understandings of normalization focused on the basic rights of the *individual*, Wolfensberger's reformulations stressed changing the social status of the devalued *group as a whole*: "the right not to be segregated and institutionalized ... is really a bigger issue than the restriction of individual choice" (Wolfensberger 1980:93, cited in Emerson 1992: 12).

While the emphasis on decent standards of living has been a positive result of normalization, the primary contradiction remains: while normalization tries to revalue those with disabilities, it is based on a hostility towards and denial of "differentness" (Szivos 1992:126). The very assumption that to be valued, disadvantaged groups should attempt to fulfill society's idealized norms must be questioned (Szivos 1992: 127-8). Moreover, assimilation or "passing" into the "normal" culture does not necessarily work, and is not necessarily a good thing. For example, normalization stresses paid and meaningful work, but people with disabilities are often marginalized at work, and can only earn a limited amount or they risk losing benefits which they receive as a result of their being "unfit to work." The discussion that follows concerning work and normalization is also significant in that Foucault (1965:58,59) has shown how the "great confinement" of the seventeenth century marked the time when the "mad" came to be perceived as those unable to work or integrate into society. Thus, there was a need to "shut up" the "mad" and others in order to correct their idleness: "Hence the Hospital ... will have not only the aspect of a forced labor camp, but also that of a moral institution responsible for punishing, for correcting a certain moral 'abeyance' which does not merit the tribunal of men, but cannot be corrected by the severity of penance alone" (Foucault 1965:59).

Strategies of "Normalization:" To Work or Not to Work

Many of those I interviewed in 2001, in the context of my Master's research, were either unable to work or had great difficulty working, because of their illnesses, work-related stress, overmedication and stigmatization. As Ethan, an artist by profession, explains, the working world is one of the many spheres in which he is "on the edge:"

... work – I have to take it easy, relationships are a little difficult because currently I don't fit in the world. I don't exist in the real world ... I'm on the edge, I'm on AISH (Assured Income for the Severely Handicapped), I'm marginalized, I live in a marginalized community ... I don't have a good regular job like everyone else. I have to live with what I've got. I don't have a spouse because it's difficult for me to meet people.

Still, Ethan was also drawn to normalization, and insisted that,

if I was in a normal state, I'd be productive. I know painters who are so-called "normal" and they consistently paint every day, 8 hours a day ... when you're depressed, you can't do that. I wonder what Van Gogh would be like if he was not bipolar ... if he was normal maybe he would have cranked out twice as much and maybe it would have been just as good.

Ethan's statements clearly show the pattern of oscillation between recognition of differences and desire for normalcy that Becker (1997:16) encountered in narratives of people with "disrupted lives."

Similarly, Tom's comments constitute a "doubled discourse" (Rapp 2000:202) of acceptance of difference and working toward normalization. Reflecting on schizophrenia, he said, "I don't know if you're born with it or not, and if you are, I think it's just an unnurtured gift that's out of control ... maybe we do produce too much of one chemical but maybe that's meant to be for things to come to pass what are supposed to in certain peoples' lives." On the other hand, Tom insisted that the medications really work as they keep him balanced, so that he does not, "go from one extreme to the other;" and he offered the following desire for the future treatment of individuals with schizophrenia: "hopefully, a few generations down the line, we can teach them how to grow up to make 'em feel more normal or train them differently so they can excel more better."

While Canguilhem suggested that patients decide when they have returned to normality, Ethan's next statement complicates the issue:

most of us forget what the hell normal is. I think it's all contextual based on the day ... the problem for a lot of people is that you get put on mood stabilizers and that definitely does not put you to normal. If you're not on it you're not normal, if you're over-medicated you're not normal, if you're under-medicated you're not normal, if you're having a shitty month you're not normal. It's hard to determine what a normal state of being is. What was normal for me when I was twenty-five years old is not normal now. What's normal now changes all the time.

Becker (1997:200) notes that qualifying the meaning of normal, as Ethan does with the phrase, "normal for me," is part of the struggle to come to terms with discourses on normalcy through reshaping one's own idea of the "normal." Lam's reflections on normalcy also complicate Canguilhem's assumption: "I still haven't figured out what normal is...my therapist said, 'things are pretty normal in your life.'" I said, 'Last month you wanted to talk to my psychiatrist. How can you detect when things are normal?' And he couldn't answer that - normal is iffy." Tyler explained that he's "trying to stay as sane as I possibly can, which is what everyone's trying to do." He described it as, "walking the edge of this table – I don't know whether I'll fall off it or go over here and be really sane or normal, whatever normal or sane is."

While neither Ethan nor Tyler were working at the time of the interviews, and Lam was working only part-time, a number of participants felt that being able to work helped them cope with their illnesses. Carolyn explained that despite her schizophrenia, she is, "really working towards having as normal of a brain as possible and making the illness as small of a problem as possible." She also commented on how her normalization has been received by her family: "now that I am treated and going to school and working and leading a normal life, they are very happy and relieved." Tina, who was diagnosed with bipolar affective disorder, also used normalizing discourse, insisting that, "the medications work; I would say I'm almost back to my normal self." Similarly, Marilyn, who had a diagnosis of schizophrenia, explained that she went through a period during her illness when she realized, "my life was never going to be normal again. Now, thank God to newer

medications, I'm back circulating in what I consider normalcy ... but it took, like, thirteen years." These normalizing statements, in contrast to those of Ethan and Lam, lend support to Canguilhem's statement that patients decide when they have returned to normality.

Kirsh (2000:4) explains that many people with mental illnesses who advocate for fuller integration into mainstream society push for total community participation, and view work in terms of "citizenship behaviors" that add to community life, as well as self-advancement. "Consumers," in her research, viewed work as something that moved one's focus from differences between those with mental disorders and others to similarities; as Susan stated, "there, I'm a worker who does a good job, gets paid and earns a living like anybody else. I'm almost normal." Many of the consumers in Kirsh's (2000:10) study who worked, "described improved mental health and self-esteem and a more integrated, 'normalized' way of life." These individuals agree, on a certain level, with "normalization," and see themselves not as normal, but in the process of being normalized.

In contrast, Estroff (1981:132) found that about 75% of the clients registered in P.A.C.T. (Program for Assertive Community Treatment) were constantly unemployed, despite the normalization philosophy of this program, which heavily emphasized finding and maintaining employment. The findings are partially a result of the fact that some clients defined work differently; for example, George's "work" involved attending religious services and classes and organizing a public ministry, while Sadie eschewed "work," preferring to talk with people and wonder about the nature of existence (Estroff 1981:141). Still others lacked any motivation to work, which can be attributed to their predictions that they would get fired or end up quitting, their refusal to accept menial work, or the fact that they could rely on financial assistance (Estroff 1981:142). There was also a disinterest in conventional employment for reasons such as restrictions of symptoms, and the feeling that all one's energies were needed just to make it through the day. For example, Morris told staff, "I'm a little too mentally ill to go to work today" (Estroff 1981:141).

"Making It Crazy"

This statement also points to the fact that while some clients reject the "normalization" mandate to take up conventional

work (or any work, for that matter), there is a certain acceptance of the "dividing practices" that have led to them being labeled them "mentally ill." This is also evident in Estroff's research in clients' distinction between themselves – "Crazies" – and others – "Normies." Similarly, Harold said that he didn't believe he was really crazy, but that "the only time I ever do think I am is when I can't believe some of the things I pull to get into the hospital. I guess I just feel like I belong, or it's more secure, or something" (Estroff 1981:231). Estroff (1981:237) suggests that when people express a lack of intersubjective reality with others, they must accept this "different" reality, and when this reality is threatened, by techniques of psychiatric normalization, for example, they may react by defending the "crazy self." Moreover, Estroff (1981:244) maintains that we are all complicit in "making it crazy," a process in which, "long-term psychiatric patients are entwined in the paradoxes of constructing and living with a crazy identity and with uncertain illness in a sociocultural environment that communicates and denies, enhances and devalues who they are and how they are."

The rewards of normalcy, from the point of view of those who feel and act differently, may pale in comparison to the "advantages" of accepting the "crazy" identity. However, by grasping the crazy identity and thus, maintaining control over their identities, they are marginalized socially. These findings lend support to Ong's (1995:1244) critique of Foucault's analysis of how individual bodies and the social body are adjusted to normalizing standards: "he barely explores how the subjects of regulation themselves draw the medical gaze in the first place, nor how their resistances to biomedical intervention both invite and deflect control."

The attitudes of P.A.C.T. clients involved in "making it crazy" differ greatly from members of another P.A.C.T. organization, whose acronym stands for People Against Coercive Treatment. These "psychiatric survivors" came together to try to stop changes to the Mental Health Act that would allow forced psychiatric treatment in the community. Their mission statement, which shakes an accusatory fist at the Ontario government, psychiatrists, and pharmaceutical companies, makes clear their stand of resistance to and rejection of normalization:

after all, if they can drug enough hurting, vulnerable, desperate people to make them forget why they are hurting so badly, if they can sweep the homeless into prisons and institutions to keep them out of sight and out of mind, then maybe they can pretend that they are responding to public concern as they line the pockets of rich doctors and drug manufacturers ... we are ... punished for being what we are, told we're insane because we don't conform, beaten into submission both physically and mentally.... WE DON'T HAVE 'BROKEN BRAINS,' WE HAVE SHATTERED SOULS.

While the position of these "psychiatric survivors" is certainly a rejection of normalization as I have been discussing this concept, Estroff (1991:337) highlights a different strategy of "normalizing," which aims at recategorizing either the individual as non-pathological, or the disorder as one that occurs commonly in others. The excerpt from P.A.C.T.'s mission statement corresponds with the former strategy, while the following statement made to Estroff (1991:331) represents the latter: "I think everybody's got a little mental illness. It's just some know and some don't" (Estroff 1991:331). Many of the participants in Estroff's study spoke of how emotional problems are not mental illnesses, because everybody has to deal with stress every day.

Similarly, Schneider (forthcoming) notes that participants diagnosed with schizophrenia use similar normalizing strategies. For example, Marie explains her delusions during the exam period: "I just see it as a natural process of having stress in accordance to schizophrenia....other people have stress in other forms. Because I have these unique perceptual experiences, I experience the stress in a different form." One of the participants in my research offered this expanded version of "everybody's got a little mental illness:"

I personally think everybody has bipolar illness: some are in the middle with their chemistry, some definitely get blue, short term, some get happier than others. But in our case, we're more bipolar 1s or 2s or 3s, which is just a different range of it. But I think we're just a bag of water and chemistry, eh ... that's what we are – chemicals, and I think it's within the human range. And I think we've been given labels to all these things ...

For the larger society, "schizophrenia" and "mental illness" hold few meanings understood as "normal" or positive, yet these individuals assert the "normalness" of this category. A Foucauldian perspective might critique such strategies of normalization, arguing that they continue to act as mechanisms of control that homogenize society and deny differences. However, Schneider (forthcoming) points out that not only does such normalizing talk help individuals to create a more positive personal identity, but it also contributes to the definition and re-definition of the boundaries and meanings of the very categories of mental disorders. These findings lend support to Lupton's (1997:94-5) critique of those using a Foucauldian framework, who tend, "to neglect examination of the ways that hegemonic medical discourses and practices are variously taken up, negotiated or transformed by members of the lay population in their quest to maximize their health status..."

Resisting "Normalization"

To define the normal in terms of adaptability and fitness means that attention must be paid to the question of to what and for what we determine adaptability. Canguilhem (1978:176) noted that defining abnormality in relation to social maladaptation requires an acceptance that the individual must subscribe to such a society, and must accommodate herself to it as a reality which is also a good one. Foucault (1982:216) takes this line of thought further, suggesting that "maybe the target nowadays is not to discover what we are, but to refuse what we are...We have to promote new forms of subjectivity through refusal of this kind of individuality which has been imposed on us...." Such an effort to "refuse what we are" can be seen in the various strategies by which individuals reject the normalization mandate. An explicit example is provided on the website for "The Mental Illness Education Project, Inc." in the following excerpt from an article by Patricia Deegan (1996):

The goal of recovery is not to get mainstreamed. We don't want to be mainstreamed. We say let the mainstream become a wide stream that has room for all of us and leaves no one stranded on the fringes. The goal of the recovery process is not to become normal. The goal is to embrace our human vocation of becoming more deeply,

more fully human. The goal is not normalization. ... one of the most essential challenges that faces us is to ask, who can I become...?

A minority of the participants in my research subscribed to this anti-normalization mandate, offering alternative understandings of their diagnosed conditions. For example, Alexander, a screen-play writer, insists that bipolar affective disorder enables him to create:

for someone like me, someone who is thinking I'm an artist, that's kind of, I don't know, maybe it sounds strange, but it's kind of good, because it's special. Only 1% of the population have this disease. And lots of writers and composers have same disease. That means maybe I could be...I don't think ordinary people can feel this colour and this light and these crazy things in my brain. It could be really good for creative work....I got something from something, so I have to use this ability. So I think this is *ability*. It's a good thing.

Another participant diagnosed with bipolar affective disorder stated: "I keep looking for these Goliaths that I want to be David to ... I think I've created for myself existential despair or existential problems." Jenny went on to speak of how existential despair is part of a search for meaning, and interpreted her disorder within this framework; she would likely agree with the point made by Shorto (1999:15) that, "by looking at psychosis as a mere illness ... psychiatry misses the whole point of the affliction: that it is ultimately an attempt to find deeper meaning."

When I asked how the medical professionals had explained the disorder, Jenny said, "the doctors explained ... nerves in the brain and all that jazz – I'm too stubborn to settle for burying the stuff under the pile of drugs. Maybe it's just not possible to sort out your existential despair – you'd have to change the world too much." Jenny's comments reflect Karp's (1996:178, cited in Fee 2000:90) statement that as our society becomes more and more medicalized, a "culturally induced readiness to interpret pain as illness," is evident. During the group interview, which took place two days after the terrorist attacks of September 11th, Jenny insisted that, "if you have a disorder

and the norm is the other kind of people ... I personally believe that the society is just as crazy as I am, and the last couple days has been proof of that!" This statement is an apt illustration of Gottschalk's (2000:22) point that explaining mental disorders as individual problems, rather than critically assessing the sociocultural environment, supports the idea that the existing social order is sane, and "normal" (conforming) social/psychological dispositions are healthy. Social forces, then, may be pushing us into a "normal madness."

Dee, a participant diagnosed with schizophrenia, noted that among native groups, "people like me would become medicine men." Instead, she says, "the white man's still torturing their spiritual leaders," and added the following about the way mental illnesses are approached in our society, or rather, the way they are not approached:

I don't know whether they're so right in taking mental illness and sort of chopping it all up and puttin' it in these categories and labels. And I wonder if there's a lot more there that they don't understand; that really we're going backward in time when we should be going forward ...

Later Dee reflected Jenny's beliefs about the cause of her disorder being partially rooted outside of herself, in society: "from my own personal point of view, a lot that contributes to the unbalance is stress in the society ... perpetuates the illness."

Questioning the meaning of the voices that those diagnosed with schizophrenia hear, Dee wonders if they are picking up voices from minds: "there's a lot more happening than it being just an illness ... may be part of a sixth sense that's not developed in a nurturing environment...it will come to light that it's a very valuable part of the evolution of humankind." While mental disorders may not be "normal," then, they are not something to be devalued as "illnesses" and "normalized." Dee's words and her later comment that her mental disorder has made her more aware of the fact that all of us are connected, reflect the beliefs of proponents of the psyche-spirit movement and consciousness studies, who reject traditional understandings of what human beings are, how we know and what knowledge is composed of; along with Dee, they "assume that individual consciousness is broader, weirder, fuzzier than we normally allow, that it somehow or other

extends beyond the skin of the individual person" (Shorto 1999:225).

During a group interview, Lyle explained the essence of psychiatry: "*your mind's gone wrong, or something, in somebody's eyes.*" His challenge to the authority of normalcy is strikingly evident in his description of how individuals with mental illness are treated, which evokes Canguilhem's statement concerning "stimulating modification" as well as Foucault's discussion of technologies of normalization that impose homogeneity:

I believe I have been enriched by my illness because I think I've had a wider expression of emotion because of it ... but people around me don't necessarily want that or allow that so they medicate you or hospitalize you because they can't cope, it isn't within their realm. And so, in order for you to fit the norm of what everybody else wants, you're hospitalized and it's taken away from you and then the medication makes you like a zombie. How can that be better? So in a way, I feel it's very progressive, it's very creative, it's very advanced and I think you can relate in a different way to things because of it ... you could say it's a gift ...

All of these anti-normalizing statements reflect Estroff's (1981:215) caution that we need to avoid ethnocentricity in assuming that "normalcy" is equally attractive to people, particularly to people who receive signs that they are different.

Another Way of Life

These narratives also support Canguilhem's (1978:64) contention that disease is really another way of life; those diagnosed with mental illnesses are living another life, and are therefore different, rather than deviant. Another example of this qualitative difference is the "particular form of being-in-the-world" of people with schizophrenia that Corin (1990:171) encountered in a Montreal hospital. While "social deinstitutionalization" or "community integration" is often assumed to have a normalizing effect, Corin (1990:170) found that, "the ability to remain within society is not associated with resuming a 'normal' well integrated position." Rather, those who avoided rehospitalization adopted a personal stance of "detachment" toward the outside world, which was manifested in "symptoms" of "emotional

withdrawal," "poor rapport," etc. While such "symptoms" are traditionally linked to poor outcome, Corin (1990:170) reconceptualizes them as "positive withdrawal," as they are associated with the ability to remain within the community.

The critique offered in her conclusion is useful to keep in mind when we consider the constraints on individuals' strategies of conforming to or resisting normalization. Strategies of relating to the world by those with schizophrenia are fragile, which, in contrast to therapeutic possession rituals in some cultures, "reflects the absence of cultural processes allowing people to go back and forth between marginal and normal positions...differences remain trapped at the periphery and that would qualify a withdrawal process with irreversibility" (Corin 1990:184). While "integrated" on a superficial level, the participants in her research remain "on the edge."

Most participants who explicitly reject "normalization" would likely agree with a "recovery" model that is based on valuing those who are different, and not just those who "fit in" by "passing as normal:" "one can be 'disabled' and positively different – exactly as one can be 'mad and proud' (Sayce 2000:132-3). This statement, however, needs careful consideration in light of Dumont's (1983:260, cited in Corin 1990:183) insistence that, "if the advocates for the difference call together for it equality and recognition, they call for the impossible." Dumont is referring to the ambiguous nature of "individuality," which signals simultaneously the promotion of self-realization and a uniform notion of what individuals should be; hence, "individuality," "atomization," "identity" and "equality" are closely connected, resulting in the subordination of differences (Corin 1990:183). Corin (1990:183) points out that while a tolerant attitude would acknowledge differences and accept or transcend them, the attitude of North Americans toward marginality is really "indifference," which sees differences as of little value. She highlights the importance of normalization philosophy in rehabilitation as an example of how differences are negated.

On the other hand, as Becker (1997:202) found in her research in the United States with people who have various disabilities, resistance to normalizing ideologies can be creative and transformative. This is also evident in some of the narratives given by my research participants. An interesting example of the transformative potential of resistance to

"normalization" is the Hearing Voices Network, which encourages people to redefine their experience in ways which reject the role of victimized patient (Romme and Escherr, 1993, cited in Burr and Butt 2000:203). This specialized self-help group network was initiated by Dutch psychiatrist, Dr. Marius Romme, when he discovered that many voice-hearers were living successfully in society. The basis for this movement in the UK is that psychiatric medications do not work in the long term, while learning to accept and live with hearing voices has met with success. While there are no branches of this network in North America yet, it appears likely that the success of this movement will lead to its development here as well, particularly as there are a number of psychiatric survivor groups, whose members draw upon anti-psychiatry literature to reformulate their conditions and resist normalizing ideologies.

Groups like the Voice Hearers Network, as well as individuals who are shifting the boundaries of normalcy, or rejecting them altogether, provide a powerful counterpoint to statements such as the following: "the specification of 'normality' has become narrower and more stringent – it is easier to fall outside of the specifications where the penalties are harsh (institutionalization)...to qualify as a 'normal' person one must torture oneself in relation to strict and constricting criteria" (Eckermann 1997:158). While there may be some truth in this statement, it is misleading when we consider the various strategies implemented by those diagnosed with mental illnesses.

Interestingly, the Voice Hearers Network rejects normalization in that it does not attempt to "make normal," those who hear voices; however, it constitutes a normalizing rationale, in that it makes "normal" the phenomena of voice hearing. It was through a radio appeal, that Romme established that hearing voices was actually a widespread experience, but only problematic for a minority (Clarke 2001:12). Referring to the Hearing Voices Network, Clarke (2001:12) notes that "a normalizing rationale is a powerful tool in building the therapeutic alliance In ...psychosis, the normalizing rationale adds to this a way of making sense of the client's predicament which offers less stigmatization and more hope of control than the traditional one." This statement underlines what should be clear by now: any simplistic assessment of "normalizing" as being negative (or positive) or

rejection of "normalizing" as being positive (or negative) cannot be made.

Multiplicity of Strategies and Doubled Discourses

It is imperative that we do not fall into the trap of declaring normalizing discourses the dominant discourse and resistance to normalization the subjugated knowledge, and then attaching value to one or the other in a polarized fashion. The diverse strategies used by those diagnosed with mental illnesses foreclose such a myopic judgment. As Foucault (1978:100) put it, "we must not imagine a world of discourse divided between accepted discourse and excluded discourse, or between the dominant discourse and the dominated one; but as a multiplicity of discursive elements that can come into play in various strategies."

Goffman (1963:138) stated that, "the normal and the stigmatized are not persons but rather perspectives." It seems clear that discourses of normalization and resistance to normalization are as various as the unique individuals and their perspectives. I have discussed those who use normalizing talk to make claims of being "inside" the realm of "normalcy," rather than "on the edge." A number of those diagnosed with mental illnesses utilized a doubled discourse of accepting difference but working towards normalization. Others rejected the normalization mandate, but accepted the dividing practices that led them to be "mad and proud." Those who claimed to have "shattered souls" resisted both normalization and the dividing practices that labeled them "mad." However, the complexity of concepts of "normal" and "normalization," is evident in the fact that these P.A.C.T. members also subscribe to a normalizing rationale in their recategorization of themselves as non-pathological. Similarly, the Voice Hearer's Network represents a rejection of normalization through the rejection of the connection between hearing voices and "illness;" however, it is normalizing in that it makes normal the phenomenon of hearing voices. Other normalizing strategies used included the recategorization of mental illness as occurring commonly among others, and emphasizing the "normal" aspects of the disorder. Resistance to normalization was evident in participants who understood their "disorders" as "progressive," "ability," "good for creative work," or "a gift."

In regard to normalization, Estroff (1991:363) issues the following caution: "perhaps chronicity and disability begin when normalizing talk ends, or when the individual thinks that no one else is listening. One compelling challenge for anthropologists and clinicians alike is to keep the conversation going." Similarly, promoting a movement towards reduced social exclusion of people with mental illnesses, Sayce (2000:36) suggests that we need to start by listening to what those "on the edge" are trying to tell us. While I agree with Estroff and Sayce that we need to listen to those who are "on the edge," I am not sure that keeping the conversation of normalizing going, or decreasing "social exclusion" should be our primary goals in every instance. Is it worth it, after all, if social inclusion requires homogenization: "Does assimilation to the dominant center represent resilience or self-negation? ... what healthy outcomes can realistically be expected, and at what cost for the marginalized?" (Hall 1999:98).

In reference to homelessness and mental illness in New York City, Hopper (1988:165) suggests that the assumption that mental disorders are responsible for homelessness has the effect of, "transforming the meaning of life at the margins, leaching it of any residual elements of refusal or defiance." The question of whether there is value in "life at the margins" that will be lost with "social inclusion" must be considered. The transformation of the meaning of life "on the edge" should be effected, as much as possible, by those who occupy this margin. Another question to consider is raised by Hall (1999:90): "Can one be marginalized, yet not oppressed?" She also asks whether those who we have been discussing as "on the edge," or marginalized, are actually exteriorized – outside of the system. Are people labeled "schizophrenic" considered "persons" in our society? (Hall 1999:96).

Looking toward the future, the Director of the National Institute of Mental Health in the United States has made the following statement:

By 2020 it will be a truth, obvious to all, that mental illnesses are brain diseases that result from complex gene-environment interactions. We will be reaping the therapeutic benefits that accrue from the discovery of risk genes for ... schizophrenia, manic depressive illness and other serious mental disorders. We will also routinely analyze real-time movies of brain activity ... we will see the

activity of distributed neural circuits during diverse example of normal cognition and emotion; we will see how things go wrong in mental illness; and we will see normalization with our improved treatments (Hyman cited in Goldsmith 1999:2293).

Such a prediction leads to the possibility that more support groups will appear for parents of those individuals unfortunate enough to be born with such "risk genes" and possibly even support groups for the children themselves; such a construction of collective identity by way of emergent categories of biomedicine has been termed "biosociality" by Rabinow (1992:58). However, even if this notion of the origin of mental illnesses does become "obvious to all," and "risk genes" and improved treatments are discovered, as this paper has shown, "normalization" is not a certainty. Some will try to "pass for normal," while others will remain "more than passing strange," while others will engage in the myriad of complex, and often contradictory strategies of normalization and anti-normalization, of which this paper offers but a glimpse.

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